Exhibit 19

UCSF Medical Center
UCSF Benioff Children's Hospital

June 28, 2016

Maha B Toma, MD
3468 Mt Diablo Blvd #C-104
Lafayette CA 94549

MT
please scan
July 1st 2016

UCSF Helen Diller Family Comprehensive Cancer Center Thoracic Medical Oncology Program
1600 Divisadero 4th Fl
San Francisco CA 94115-3010
Phone: 415-885-3882
Fax: 415-353-7151

Patient: Stephan Lanzo
MR Number: [redacted]
Date of Birth: [redacted]
Date of Visit: 6/28/2016

JUL 15 2016
CSN: [redacted]
Lanzo, Stephan
MRN: [redacted]

Dear Dr. Toma:

I had the pleasure of seeing your patient Stephan Lanzo for follow up in UCSF HELEN DILLER FAMILY COMPREHENSIVE CANCER CENTER THORACIC MEDICAL ONCOLOGY PROGRAM.

SUBJECTIVE
Stephen Lanzo is a 43 y.o. male who presents with a diagnosis of ipsilateral right-sided hemithorax malignant pleural mesothelioma epithelioid type. He began experiencing several symptoms a few months ago,which included night sweats, numbness or tingling of both arms, palpitations. He had a full cardiac workup which was negative. He noted some moderate stamina decrease and a modest amount of unintentional weight loss. His negative cardiac work up prompte initiating a radiographic work-up which is noted below:
December 12, 2014 chest x-ray negative
March 29, 2015 chest x-ray negative
April 5, 2015 chest x-ray cardiomegaly with mild central pulmonary vascular congestion
April 13, 2015 chest x-ray negative
May 15, 2015 CT chest abdomen and pelvis with contrast shows minimal pleural thickening/atelectasis of the right major fissure, prior granulomatous disease with a few calcified granulomas within the lungs, 2 mm groundglass pulmonary nodules within the left lower lobe nonspecific, no enlarged thoracic abdominal or pelvic lymph nodes
June 17, 2015 chest x-ray negative
July 28, 2015 CXR-1V negative
August 31, 2015: X-ray negative
Oct 2, 2015: ultrasound head Neck soft tissue, isoechoic 1.9 cm nodule at the isthmus

EXHIBIT
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Dec 22, 2015 CXR negative
Feb 24, 2016 CT head w/o contrast: Negative noncontrast CT of the head. No acute intracranial abnormality
Feb 24, 2016, CT thorax w/o contrast: 1. Increased pleural thickening or noncalcified pleural plaque along the right major fissure and anterior right hemithorax along the right upper lobe. Benign or malignant pleural disease should be considered. Recommend correlation with a hybrid PET/CT or tissue sampling.
2. No pulmonary consolidation or thoracic adenopathy. No pleural or pericardial effusions
–There are no pleural or pericardial effusions. No mediastinal or hilar adenopathy. No enlarged axillary nodes. There is a normal-size thoracic aorta. The lung windows demonstrate no pulmonary consolidation. There is increased pleural thickening along the right major fissure, with the largest noncalcified pleural plaque measuring 3.6 x 1.0 cm, inferior to the minor fissure. Thickening of the right major fissure superior to the minor fissure is also noted, measuring 2.8 x 0.5 cm. Increased pleural thickening is also seen along the right upper lobe, deep to the right 4th rib, measuring 1.5 x 0.7 cm. Noncalcified pleural plaque is seen along the right diaphragm (image 98). There are punctate calcified granulomas seen in the right lower lobe (image 95) and left lower lobe (image 99). The visualized portions of the upper abdomen are unremarkable. The osseous structures are intact.
March 17, 2016 PET/CT shows unilateral, multifocal, hypermetabolic, right hemithorax sequentially enlarging pleural soft tissue noncalcified abnormalities. Nonspecific tiny parenchymal nodules, one being calcified. No lymph node involvement or distant metastatic disease. In more detail, unilateral hypermetabolic pleural fissural and nonfissural soft tissue abnormalities, including right posterior costophrenic recess SUV 7.4, Soft tissue thickening and wanted to aspects of the right major fissure SUV 7.4, second major fissure component SUV 4.6, lateral pleural-based soft tissue SUV 6.2 lateral to the right upper lobe superior to the lateral aspect of the minor fisaure, another component medial to the right lower lobe T6 SUV 6.0 the right lower lobe posterior to the diaphragm down 4 mm noncalcified nodule in change.

Mar 29, 2016: Excision biopsy of pleural masses, post flex bronch. Dr. Tsai at John Muir Medical Center:
"I could easily identify the pleural masses. Both masses were completely excised and passed into an endocatch bag for pathology. I then inspected the fissure between the RUL and RLL and I could see the lung mass. I performed a wedge resection using Endo-GIA staplers to resect the lung mass. This was also passed off the field as a specimen. All frozen specimens showed malignant cells."
cultures show Propinoibacterium.
Lower pleural-based mass excisional biopsy of malignant mesothelioma, epithelioid type.
Lower pleural-based mass excisional biopsy of malignant mesothelioma, epithelioid type

Upper pleural mass, excisional biopsy of malignant mesothelioma, epithelioid type, Invasion into adipose tissue and skeletal muscle
lung mass, wedge biopsy, metastatic malignant mesothelioma, epithelioid type, grossly present at stapled surgical resection margin
tumor cells are strongly positive for calretinin, D2-40 and postivie patch CK7. Negative CK20, TTF-1, and 8, CDX 2, P 40, PAX 8 and GATA- 3
April 8, 2016, patient started cisplatin, pemetrexed, and bevacizumab with Dr. Michael Sherman
He was seen by Dr, David Sugarbaker at Baylor and by Dr. Sukhmani Pada at Stanford. His case was discussed at Stanford Thoracic Tumor board. He was seen at UCSF by Dr. Jablons and his path biopsy specimen was reviewed and confirmed to be epithelioid meso by Dr. Jones at UCSF.

PAST MEDICAL HISTORY:
1. GERD
2. Barrett's esophagus

SOCIAL HISTORY/HABITS:
Married with three children (8,6,4 y/o). Worked in Finance and lives with his family in Lafayette. He is a social, light drinker and a never cigarette smoker with rare cigar smoke, none since 2010. He may have had a remote history of indirect asbestos exposure when visiting a grandfather as a child. His grandfather was likely exposed to asbestos through his work in Connecticut.

FAMILY HISTORY:
No family history of mesothelioma. His father has history of recurrent skin malignancies. Maternal grandmother with history of breast cancer in her 70's.

Interval History 06/28/16:
Last visit, 4/29/16, the patient had completed his first cycle of cytotoxic therapy with pemetrexed/cisplatin/bevacizumab in early April 2016. We supported the continuation of chemotherapy and investigation of potential surgical interventions.

Since the last visit, the patient states he is having difficulty tolerating chemotherapy. He c/o of acute pain in his throat coincident with his last cycle of chemotherapy and persistent pain with swallowing. He has been experiencing mild hemoptysis with Avastin therapy. He plans to undergo a pleurectomy and intrapleural platinum on July, 26 with Dr. Sugarbaker at Baylor. He plans to undergo a repeat PET-CT scan next week. He will suspend chemotherapy prior to surgery. He continues to have regular night sweats and intermittent discomfort and pain in the chest. Mild right-sided hernia from prior chest tube has resolved.

ROS
+night sweats
All other review of systems negative, except for those noted.

Patient denied the occurrence of:
fever, chills, hemoptysis, anorexia, hematemesis, melena, hematochezia, hematuria, dysuria, flank pain, nausea, vomiting, headaches, blurred/double vision. The remainder of the 14 point review of systems was otherwise negative. ECOG PS=0-1

MEDICATIONS
Current Outpatient Prescriptions

Medication	Sig	Dispense	Refill
• omeprazole (PRILOSEC) 20 mg capsule	Take 20 mg by mouth Daily.		

No current facility-administered medications for this visit.

ALLERGIES
No Known Allergies

PHYSICAL EXAM
Objective
Vital Signs:
Visit Vitals

• BP	123/84
• Pulse	70
• Temp	35.4 °C (95.8 °F) (Oral)
• Resp	18
• Wt	93.8 kg (206 lb 12.8 oz)
• SpO2	98%
• BMI	29.94 kg/m2

Physical Exam
Vitals reviewed.
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Nose: Nose normal.
Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.
No erythema in throat
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light. Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus.
Neck: Normal range of motion. Neck supple. No JVD present. No tracheal deviation present. No thyromegaly present.
Shotty lymph nodes on the right posterior triangle.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds. Exam reveals no gallop and no friction rub.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. He has no wheezes. He has no rales. He exhibits no

tenderness.
Abdominal: Soft. Bowel sounds are normal. He exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.
Musculoskeletal: Normal range of motion. He exhibits no edema, tenderness or deformity.
Lymphadenopathy:
He has no cervical adenopathy.
Neurological: He is alert and oriented to person, place, and time. He has normal reflexes. He displays normal reflexes. No cranial nerve deficit. He exhibits normal muscle tone. Coordination normal.
Skin: Skin is warm and dry. No rash noted. He is not diaphoretic. No erythema. No pallor.
Psychiatric: He has a normal mood and affect. His behavior is normal. Judgment and thought content normal.

RESULTS
LABS:
No updated laboratory findings since last visit.

RADIOLOGY:
All scans were personally reviewed and discussed in clinic with the patient.
CT Chest Outside Study 6/15/16:
Scan images available through Stanford Health

PATHOLOGY (UCSF review of outside slides from JMMC):
SURGICAL PATHOLOGY REPORT
Patient Name: LANZO, STEPHEN
Med. Rec.#: [redacted]
DOB: [redacted] Age: 43)
Sex: Male
Accession #: [redacted]
Visit #: [redacted]
Service Date: 4/15/2016
Received: 4/15/2016
FINAL PATHOLOGIC DIAGNOSIS

Review of MSUR [redacted] from John Muir Medical Center, Concord, CA:

A. Right pleura, lower pleural mass, biopsy: Malignant mesothelioma, epithelioid type; see comment.

B. Right pleura, lower pleural mass, biopsy: Malignant mesothelioma, epithelioid type; see comment.

C. Right pleura, upper pleural mass, biopsy: Malignant mesothelioma, epithelioid type; see comment.

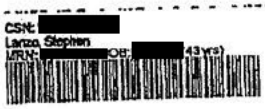
D. Right lung, lung mass, biopsy: Malignant mesothelioma, epithelioid type; see comment.

COMMENT:
Thank you for the opportunity to review this case. We completely agree with the original pathologist's diagnosis of an epithelioid type malignant mesothelioma in this case.

H&E sections of all four parts show a proliferation of large epithelioid cells with ample pale eosinophilic cytoplasm and enlarged nuclei with coarse, hyperchromatic chromatin, growing as sheets and papillae. Focally (best seen in part C) tumor cells invade fibroadipose tissue; by report, the tumor is present at the stapled specimen margin from the lung mass (part D). Necrosis is readily identified. Mitotic activity is inconspicuous.

Provided immunohistochemical stains were performed at the original laboratory with results as follows:

-D2-40: Positive.
-Calretinin: Positive.
-CK7: Positive.
-CK20: Negative.
-TTF1: Negative.
-Napsin-A: Negative.
-CDX2: Negative.
-P40: Negative.
-PAX8: Negative.
-GATA3: Weak, patchy, nonspecific staining.



The histological features and immunoprofile are those of an epithelioid mesothelioma.
Benjamin Buelow/Pathology Resident
Kirk D. Jones/Pathologist
Signed: 4/20/2016 10:58

ASSESSMENT & PLAN
43 y.o.male with likely clinical stage II right sided epithelial MPM currently receiving treatment with pemetrexed/cisplatin/bevacizumab. At this time, the patient's presents in good clinical condition. The patient is scheduled to repeat a PET-CT scan in the following week and undergo a right pleurectomy/decortication and intracavitary platinum delivery at Baylor with Dr. Sugarbaker, provided that scans return without evidence of further spread in his chest cavity. We support his consideration of this surgical intervention, and we recommend completing two more rounds of chemotherapy, sans bevacizumab, after sugery. Given his mediastinal positivity, we would also discuss the possibility of consolidation RT to the mediastinum. Should the disease return within 6 months of surgery, we will have the option of enrolling the patient a clinical trial. With respect to the patient's throat pain, we recommend that he follow up with an ENT physician for a laryngoscopy, although we suspect that it is caused by

irritation from his prior intubation exacerbated by the chemotherapy, the possibility of other etiologies such as thrush are not implausible and would warrant intervention. We would like to see the patient back in September, 2016 for a clinic visit with updated scans. Lastly, we counseled the patient regarding genetic germline (not tumor) testing for BAP1 to assess the hereditary risk for his children.

It is a pleasure to participate in the care of this delightful man. We look forward to remaining involved in his care as you and he see fit and we will strive to keep you updated with future developments. We continue to encourage him to remain active and exercise to improve and maintain stamina, and to monitor his weight while maintaining his oral intake to ensure that it does not drop precipitously. The patient was reminded to contact his team and/or us if there are any new development regarding his condition. Our patient administrative assistant Annette Mwangi can be contacted for administrative issues at 415 353 9927, and our nurse, Evelyn Barte , RN can be contacted for health related issues by calling 415 885-3882. Both are usually available Mon-Fri 9 am to 5 pm.
After hours and weekends, if he has a local healthcare team he may want to contact them for immediate,URGENT issues. He can contact us also at 415 885-3882 for URGENT issues. He will be connected by our answering service to one of our fellows, who can help with URGENT issues.
1. The patient indicates understanding of these issues and agrees with the plan.
2. I reviewed the patient's medical information and medical history.
3. I have reviewed the past medical, family, and social history sections including the medications and allergies listed in the above medical record.
The above plan was reviewed with the patient and all questions and issues were addressed to the patient's satisfaction.

Method of education: verbal
Patient ready and able to be educated: yes
Patient/family verbalized understanding of information and instructions given: yes

Counseling performed: treatment plan and side effects
Total face-to-face time in minutes: 45 min
(If > 50% of visit) total counseling time: 40 min
Interpreter used: No

I, BLYAKHMAN, INNA am acting as a scribe for services provided by Thierry M. Jahan, MD on 6/28/2016 2:38 PM
The above scribed documentation as annotated by me accurately reflects the services I have provided.
Thierry M. Jahan, MD
6/28/2016 8:27 PM

Thank you again for allowing me to participate in the care of your patient. Please feel free to contact me with any questions you may have.

Sincerely,

Thierry M. Jahan, MD
Professor of Medicine
Bonnie J. and Anthony Addario
Endowed Chair in Thoracic Oncology

Electronically signed by Thierry M. Jahan, MD on 9/28/2016, 6:31 PM

CC
Michael Paul Sherman, MD
David J. Sugarbaker, MD.

Scans

Scan on 9/30/2016 9:16 AM : MESOTHELIOMA TREATMENT CENTER (below)